PRINTED: 05/06/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	_					IB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
		155272	B. WING		_	04/13/2	2011
NAME OF	DD OLUBER OR GURRI IEI	<b></b>	-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	K		5226 E	82ND ST		
KINDRE	D TRANSITIONAL (	CARE AND REHAB-CASTLETON	1	INDIAN	NAPOLIS, IN46250		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
•	This visit was fo	or Investigation of	F0	000	This serves as the Allegation	of	
		0088043, IN00088401,			Compliance for Kindred		
	and IN00088559. This visit resulted in a				Transitional Care & Rehabilita		
					Center-Castleton for the rece		
	1 *	ed survey-immediate			complaint survey dated 04/13 Kindred Transitional Care &	/11.	
	jeopardy.				Rehabilitation Center-Castlete	on	
					asserts that all corrections	ווכ	
	This visit was in	conjunction with a Post			described on this Plan of		
	Survey Revisit (	PSR) to the Investigation			Correction have been		
	of Complaint IN	00086031 completed on			implemented. In regards to the		
	March 9 2011.				specific deficiencies, we have		
					outlined our corrective actions		
	Complaint IN00	088043- Unsubstantiated			and continued interventions to	)	
	due to lack of ev				assure compliance with regulations and our plan of ac	rtion	
	due to lack of ev	ridence			The staff of Kindred Transition		
	G 1: (DIO)	000401 0 1			Care & Rehabilitation		
	1 ^	088401- Substantiated.			Center-Castleton is committe	d to	
		related to the allegations			delivering high quality health		
	are cited.				to its residents to obtain their		
					highest level of physical, men		
	Complaint IN00	088559- Substantiated.			and psychosocial functioning respectfully submit Kindred	. vve	
	Federal/state def	ficiencies are cited at			Transitional Care & Rehabilita	ation	
	F225, F226, and	F279.			Center-Castleton is in substa		
					compliance as set forth below	, we	
	Survey dates: A	pril 6, 7, 8, 9, 10, 11 2011			are confident that it will be for		
	1 '	dates: April 12, 13 2011			in substantial compliance with		
	Extended survey	dates. April 12, 13 2011			regulations upon re-survey.		
		000170			statements made on the plan correction are not an admissi		
	Facility number:				to and do not constitute an	ווע	
	Provider number				agreement with the alleged		
	AIM number: 10	00267130			deficiencies herein.		
	Survey team:						
	Chuck Stevenson	n, RN, TC					
	Christi Davidson						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

A97U11

Facility ID:

000172

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMP	LETED
		155272	B. WING		04/13/2	2011
				ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R	I	E 82ND ST		
KINDREI	TRANSITIONAL (	CARE AND REHAB-CASTLETON		ANAPOLIS, IN46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	(4/6, 4/7, 4/8 201	11)				
	Census bed type:					
	SNF/NF: 133 Total: 133					
	10tai. 133					
	Census payor typ	20.				
	1 3 31	De.				
	Medicare: 29					
	Medicaid: 76					
	Other: 28					
	Total: 133					
	Sample: 5					
	Supplemental Sa	imple: 3				
	11	•				
	These deficienci	es also reflect State				
		dance with 410 IAC 16.2.				
	illidings in accor	dance with 410 IAC 10.2.				
	01:4	11 A:1 10				
	· •	ompleted on April 18,				
	2011 by Bev Fau	ilkner, RN				
F0225	The facility must r	not employ individuals who				
1.0223		guilty of abusing, neglecting,				
		idents by a court of law; or				
	_	g entered into the State				
		y concerning abuse,				
	_	nent of residents or				
		of their property; and report				
	any knowledge it	has of actions by a court of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155272	B. WING		04/13/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER		l l	E 82ND ST	
KINDREI	O TRANSITIONAL O	CARE AND REHAB-CASTLETON	I	NAPOLIS, IN46250	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	indicate unfitness or other facility sta registry or licensin				
	violations involving abuse, including in and misappropriat reported immediat the facility and to of with State law thro	ding to the State survey and			
SS=J	alleged violations and must prevent while the investigated. The results of all in reported to the addesignated repression officials in accorda (including to the Sagency) within 5 wand if the alleged appropriate correct the facility failed an allegation of sand ensure reside future abuse for	entative and to other ance with State law tate survey and certification working days of the incident, violation is verified tive action must be taken. For a review and interview, to thoroughly investigate sexual abuse by 1 resident ents were protected from 1 of 3 allegations of This deficient practice	F0225	This serves as the Allegation of Compliance for Kindred Transitional Care & Rehabilita Center-Castleton for the recent complaint survey dated 04/13/Kindred Transitional Care & Rehabilitation Center-Castleto asserts that all corrections	tion ht
	Resident B.	eopardy was identified		described on this Plan of Correction have been implemented. In regards to th specific deficiencies, we have outlined our corrective actions and continued interventions to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155272		(X2) MULT  A. BUILDII  B. WING		NSTRUCTION  00	(X3) DATE S COMPL 04/13/2	ETED	
	PROVIDER OR SUPPLIER  D TRANSITIONAL (	II CARE AND REHAB-CASTLETON	S 5	5226 E 8	DDRESS, CITY, STATE, ZIP CODE 32ND ST APOLIS, IN46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Administrator, E Services, and the Clinical Operation immediate Jeopa 4/10/11, but the compliance at the actual harm with minimal harm the jeopardy because continuing inser- monitoring of en- and compliance visitation policies procedures related	e District Director of ons were notified of the rdy on 4/06/11. The ardy was removed on facility remained out of e level of isolated, no potential for more than at is not immediate the facility was vicing, educating, and apployees for knowledge with building and s and policies and ed to investigating and s of unknown injury and			assure compliance with regulations and our plan of act The staff of Kindred Transition Care & Rehabilitation Center-Castleton is committed delivering high quality health of to its residents to obtain their highest level of physical, mentioned and psychosocial functioning. The respectfully submit Kindred Transitional Care & Rehabilitat Center-Castleton is in substant compliance as set forth below are confident that it will be four in substantial compliance with regulations upon re-survey. The statements made on the plant correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.  F225	tal, We tion tial, we nd the	
	the facility failed report to the state unknown origin reviewed for injuin a sample of 5.  Findings include A 1. The record reviewed on 4/00 Diagnoses include to, borderline pe				How corrective actions with be accomplished for the residents affected.  Resident B Resident B will not be assigned male caregivers and staff have been instructed to provide care to this resident pairs for the protection of both the resident and staff.  Social Services and Administration have schedula patient/family meeting to discuss placement options with the resident and staff.	nd o in oth	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272		(X2) MI A. BUII B. WIN	LDING	DNSTRUCTION  00	(X3) DATE SURV COMPLETEI 04/13/2011		
NAME OF I	DROVIDED OD CLIDDI IEI		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF				82ND ST		
KINDRE		CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE CO	MPLETION DATE
	breast cancer, be			0	the resident.		5.112
	malnutrition, and				Resident has been placed or	ıa İ	
	indirection, div	a neparitis B.			Behavior Management		
	Resident B's adn	nission Minimum Data			Program in reference to		
		essment, dated 2/24/2011,			repeated false accusations.		
	indicated she did				Social Services will meet w	ith	
	hallucinations or	•			the resident and call her fan	nily	
					weekly x4 weeks to ensure	· 1	
	Resident B's reco	ord did not contain any			any concerns are promptly		
	documentation of	of Resident B having a			identified, resolved and that	no	
guardian or an appointed power of				long term effects are eviden	t.		
attorney.				ED/DNS will give resident	and		
					family member contact		
	A Recapitulation	of Physician's Orders for			information to ensure that a	ny	
	April 2011 had a	n physician's order, dated			concerns are reported in a		
	2/17/2011, which	h indicated "Resident is			timely manner.		
	_	ng his/her own health			ED/DNS will monitor		
	decisions."			assignment sheets and SS			
					notes to ensure compliance.		
	1	lent Reporting Form"					
	1 ^	Director of Nursing			Resident C		
	,	.) on 4/06/11 at 10:00			Resident C has been kept or		
	a.m., and comple	eted by him indicated:			Pain Management program.		
	UT 1 (D)	2/24/2011			Pain is assessed with any		
	"Incident Date: 3	3/24/2011			condition change for		
	Dagidant Name	(Dagidant D)			modifications to the plan of		
	Resident Name:	(Resident B)			Care.		
	Brief Description	n of Incident: Resident			Resident C care plan has be updated to address the fract		
	1 ^	In of incident, Resident  Juit manager and the			and pain control issues.	uic	
	sosial (sic) servi	•			and pain control issues.		
	` ′	· ·			How corrective action will	he	
	* *	* *			1 -	,	
	it happened, resi	e. (sic) when asked when dent stated it happened ont unable to describe			How corrective action will accomplished for those residents with the potential		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	155272	A. BUIL			04/13/2011
		130272	B. WING		A DEDUCA CONT. CONT. CO. CO. CO. CO. CO. CO. CO. CO. CO. CO	04/13/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 82ND ST	
KINDREI	O TRANSITIONAL (	CARE AND REHAB-CASTLETON			IAPOLIS, IN46250	
					1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	what happened w	when asked asked if			to be affected.	
	1 ^^	no did it, he (sic) said his				
		and he does not work			Resident interviews were	
	here, asked if she	e could describe him, all			conducted on April 10, 2011	1 to
	she said was, he	is dark skin and has good			ensure that no other allegati	ons
	grade hair. reside	ent she (sic) gas already			of abuse were present.	
	told her husband	and her daughter and			Department Heads were	
	that they will be	picking her up after			educated by ED/DDCO on	
	work. resident co	ontinue to repeat the same			4-7-11, Staff Development	
	statement over a	nd over. she was unable			Coordinator on 4-20-11, and	d
	to give any furth	er information and			4-21-11 with respect to poli	cy
	description when	asked. when questioned			and procedure	
	if she screemed (	sic) she said yes, staff			reporting/investigation of	
	came in but the r	nan has already left."			allegations.	
					Staff was educated on 4-7-1	1,
	1	ident Reporting Form"			4-12-11, 4-21-11 and 4-	
	1 ^	I not document the date			21-11 with regards to the	
	1	t was completed, or the			immediate reporting of any	
	time Resident B	made the allegation of			such allegations of abuse to	the
	rape.				ED/DNS/designee.	
					ED is taking disciplinary	
		ess Note, dated 3/25/11 at			action with Staff regarding	
	· ·	ated "Reported to this			failure to follow the Abuse	
	` ′	ocial Service Director			Policy and protocol and the	
		le an allegation of			need to report incidents	
		sident-stated 'I was			immediately.	
	_	she knew when it			ED met with Resident Cour	<b>I</b>
		Yes it happened last			on April 29, 2011 to review	
	night'"				Abuse Policy and protocol a	and
		(F. (D. )			the need to report incidents	
	1	ent Event Report			immediately.	
		ived from the D.N.S. on			If a resident has a fall and a	<b>I</b>
	_	.m., indicated the			subsequent negative x-ray f	or a
	Administrator ha	d been advised of			fracture, and resident	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155272	B. WIN	G		04/13/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
				1	82ND ST	
KINDREI	) TRANSITIONAL (	CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE .
	· '	gation of rape on 3/25/11			continues to complain of pa	
		ring an interview on			or demonstrates any change	
		.m. the Administrator			condition, the resident will l	
		d not participated in any			sent to the hospital for furth	er
		tigation of Resident B's			evaluation.	
	allegation of rape	€.				
					What measures will be put	
		nterviewed on 4/07/11 at			place/systemic changes ma	ıde
		vate in her room. She was			to ensure correction &	
		perative. When asked			How the facility plans to	
	_	ion of rape, she refused to			monitor its performance to	
	discuss it and end	ded the interview.			make sure those solutions	are
					maintained.	
	During an intervi	iew with the Social			All doors will be locked 24/	7.
	Services Worker	on 4/07/11 at 5:00 p.m.,			The main entrance will be	
	with the D.N.S. a	and Administrator present			staffing during normal	
	she provided cop	oies of two resident			business hours.	
	interviews, dated	13/25/11, she indicated			Cameras will be installed at	
	she did following	g Resident B's allegation			the front door entrance, the	
	of rape. The D.N	.S. and Administrator			Cambridge Unit entrance ar	nd
	had no explanation	on for why this	the staff entrance. The staff on			on
	documentation w	as not included in			the unit will have the	
	documentation p	rovided earlier.			responsibility to allow or de	ny
					entry to the facility who not	do
	A Social Service	s Progress Note, dated			not use the main entrance.	
	3/25/11 at 1:30 p	.m., indicated "This			Staff on the units will be	
	writer (symbol fo	or "and") UM (unit			responsible to ensure that	
	manager) went t	o speak to (name of			visitors sign in.	
	resident) to follo	w up with investigation.			If a visitor refuses to sign in	or
	This writer asked	d (name of resident) if she			becomes threatening in any	
	heard anything la	ast night R/T (related to)			way, the visitor will be aske	d
	neighbors on hal	l. (Name of resident)			to leave the premises. If the	y
	stated No (symb	ool for "and") that she			refuse, police will be notified	ed.
	slept all night he	*			Maintenance personnel will	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155272	A. BUII	LDING	00	COMPL	
		155272	B. WIN			04/13/2	UTT
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
KINIDDE	D TDANGITIONAL A	CARE AND REHAB-CASTLETON			82ND ST APOLIS, IN46250		
					AFOLIS, IN40250		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	neggen on or				check locks according to the	<u> </u>	5.112
	A Social Service	es Progress Note, dated			preventative schedule daily	,	
		o.m., indicated "This			and prn. The Supervisor wi	11	
	1 -	beak with (name of			be responsible for checking		
	1	rds to investigation.			doors on the weekends.	tiic	
	1 '	nt) stated he did not hear			The facility has posted notic	es	
		c (night) it was pretty			at each entrance outlining th		
	quiet"	e (mgm) it was protty			new security system.		
	quiet				Daily resident rounds will be	Δ	
	During interview	vs on 4/06/2011 at 10:30			performed by the ED/DNS a		
	During interviews on 4/06/2011 at 10:30 a.m. and again at 4:30 p.m., the D.N.S.				unit managers to identify an		
	indicated he had not interviewed any				address concerns promptly.	<b>u</b>	
	residents or staff following Resident B's				Department Managers will	he	
		e, and had not done any			educated to Kindred's Angel		
		on or instituted any			Care program by May 5, 20		
	1	assure resident safety.	and they will be required to				
	interventions to	assure resident surety.			visit their assigned residents		
	   An Immediate I	eopardy was identified on			2-3 times weekly, with a		
		o.m. The Immediate			weekly call made to the		
	1	on 3/24/11 when a			residents' responsible party		
		she was sexually			and a weekly summary turne	ed	
		dministrator, Director of			into the ED. Any concerns		
		and the District Director			will be brought to the daily		
		ations were notified of the			clinical meeting with a		
	1	ardy related to the facility's			resolution indicated within 2	24	
		t residents from potential			hours. ED/DNS will monitor		
	_	1 at 5:15 p.m. The			weekly summaries to ensure		
		ardy was removed on			resolution.		
	_	nrough observations,			Resident interviews will be		
		record reviews it was			conducted by SS, on a		
	determined that				quarterly basis, using the		
		e plan of action to remove			ABAQIS (Quality Assuranc	e)	
	_	eopardy and that the steps			system questions to ensure	~ <i>)</i>	
		he immediacy of the			integrity of the process. Any	7	
	Laken removed t	ne miniculacy of the			micegity of the process. Any		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155272			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/13/2011	
	PROVIDER OR SUPPLIER	R CARE AND REHAB-CASTLETON		STREET A 5226 E	ADDRESS, CITY, STATE, ZIP CODE 82ND ST APOLIS, IN46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E C	(X5) OMPLETION DATE
	problem. The facinterviews with a information relation assess for any has psycho-social, diresidents had, and concerns. The facility also involved staff minutes conducting inserts building security policies, policies to investigating a unknown origin. Even though the action removed a remained out of scope and severith arm with poten	cility performed multiple residents to uncover any ted to the allegations, to arm including iscover any concerns the d responded to those cility notified the local and the police investigated facility during the			concerns will be brought to ED immediately for follow of Results of the interviews will be reviewed by the ED/DNS. New orders will be reviewed in daily clinical meeting to ensure that x-rays receive timely follow up, pain medication changes are addressed, care plans are updated appropriately and condition changes are responded to expediently. An abuse in-service will be done on a quarterly basis. Clinical Case Managers and MDS coordinators will be responsible to ensure that caplans are updated timely and are comprehensive. DNS/designee will monitor care plans for compliance or quarterly basis. ED will meet with the residence of the monthly thereafter. Resident council president here informed that he may request a meeting at any time and will be given contact information. Investigations will be conducted using a systematic approach under the guidance.	/or re d a a ent a a se e c c	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/06/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPI		
		155272	A. BUIL B. WINC			04/13/2	
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				82ND ST		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-CASTLETON			IAPOLIS, IN46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	-	ID	DROVIDEDIS DI AN OE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
					of Kindred policy to ensure		
					that the investigation is		
					comprehensive in nature.		
					· Any staff member		
					accused of abuse will be		
					suspended immediately		
					pending the investigation.		
					Kindred has a zero tolerance	e	
					policy for abuse of any kind	l	
					and will take whatever steps	5	
					necessary to ensure the		
					protection of our residents.		
					· Allegations of abuse a	and	
					all incidents of unusual		
					occurrences (as defined by		
					Indiana Code) will be report	ted	
					to officials in accordance the	e	
					regulations and Kindred		
					policy.		
					5. Executive Director is		
					responsible to ensure over		
					compliance by May 9, 201	1.	
SS=J	R 1 The Clinic	cal Record of Resident C			This serves as the Allegation of	of	05/09/2011
33-3		04/08/11, at 11:50 a.m.			Compliance for Kindred	<b>21</b>	03/09/2011
	was reviewed on	04/08/11, at 11.30 a.m.			Transitional Care & Rehabilita		
	Diagnoses includ	led, but are not limited to,			Center-Castleton for the recer		
	dementia, malais				complaint survey dated 04/13/ Kindred Transitional Care &	11.	
	-	eumatoid arthritis,			Rehabilitation Center-Castleto	n	
	osteoarthritis, and	-			asserts that all corrections		
	ostooaramins, am	a unomina.			described on this Plan of Correction have been		
	   An Annual Minii	mum Data Sheet (MDS)			implemented. In regards to th	е	
		d 02/21/11, triggered			specific deficiencies, we have		
	assessificiti, uate	u 02/21/11, u1ggc1cu					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

A97U11

Facility ID:

000172

If continuation sheet

Page 10 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155272		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/13/2011	
	PROVIDER OR SUPPLIER	CARE AND REHAB-CASTLETON	STREET A 5226 E	ADDRESS, CITY, STATE, ZIP CODE 82ND ST APOLIS, IN46250	I
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Resident C as mo cognition. The M indicated Resider assistance with o transferred.  A current Recapithru 04/30/11, without of 11/19/10, indicated Resider assistance with o transferred.  A current Recapithru 04/30/11, without of 11/19/10, indicated agnosis and the company of 11/19/10, indicated agnosis and	oderately impaired in MDS assessment int C required extensive ine staff person when tulation, dated 04/1/11 ith an original order date cated Resident C "DX"		outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actine staff of Kindred Transition Care & Rehabilitation Center-Castleton is committed delivering high quality health of to its residents to obtain their highest level of physical, mentand psychosocial functioning. respectfully submit Kindred Transitional Care & Rehabilita Center-Castleton is in substantial compliance with regulations upon re-survey. To statements made on the plan correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.	tion. nal d to care tal, We ation titial d, we and the
	with the most recindicated"Resident misscommunicated Dementia, HOH  A Nurses Note, of (10:30 a.m.), ind "black discolor [right] ankle. 3cd does not know how (sic) not aware of the control of the	{hard of hearing}"  lated 03/18/11, at 1030 icated Resident C had ration on front of R m x 2cm. res. [resident] ow it happened. staff f how it happened. MD		How corrective actions wibe accomplished for the residents affected.  Resident B Resident B will not be assigned male caregivers are staff have been instructed to provide care to this resident pairs for the protection of both the resident and staff. Social Services and	nd O C in Oth
	office in facility	notified. POA [power of discountry]		Social Services and Administration have schedu	ıled

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155272	B. WIN			04/13/2011
NAME OF E	PROVIDER OR SUPPLIER	1		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
					82ND ST	
KINDREI	O TRANSITIONAL C	CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
ı	aware"				a patient/family meeting to	
					discuss placement options v	vith
		t Report Worksheet,			the resident.	
	-	t 10:30 a.m., indicated			Resident has been placed or	ı a
		interviewed relative to			Behavior Management	
	the injury. Staff	indicated they were			Program in reference to	
	unaware of the or	rigin of the injury.			repeated false accusations.	
	Resident C indica	ated in report"possibly			Social Services will meet w	rith
	when transferred	or propelling-not			the resident and call her fan	nily
	sure" The box	"Injury of unknown			weekly x4 weeks to ensure	that
	cause" was mark	ed, and the box			any concerns are promptly	
	"Circumstances I	Jnknown" was marked.			identified, resolved and that	t no
	The report indica	ted the Director of			long term effects are eviden	ıt.
	Nursing Services				ED/DNS will give resident	
	•	tifications were not			family member contact	
	applicable as ind	icated by a mark in the			information to ensure that a	nv
	box "N/A."				concerns are reported in a	
					timely manner.	
	A Nurses Note, d	lated 03/20/11, at 1830			ED/DNS will monitor	
		eated Resident C had			assignment sheets and SS	
		the right lower leg. The			notes to ensure compliance.	
	_	touch and tender when				
	moved. Resident				Resident C	
		ering service was called			Resident C has been kept or	1 a
		dy was suggested. The			Pain Management program.	
	note also indicate				Pain is assessed with any	
	supervisor was n				condition change for	
	supervisor was il	ouncu.			modifications to the plan of	,
	A Nurses Note d	lated 03/21/11, at 0800			_	
		· ·			Care.	on
	* * * * * * * * * * * * * * * * * * * *	eated"Resident cries out			Resident C care plan has be	
	1 ,	tempt to elevate legs"			updated to address the fract	ure
		ted she called the Nurse			and pain control issues.	
		and the resident's power				_
	of attorney.				How corrective action will	be
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: A	97U11	Facility	ID: 000172 If continuation s	heet Page 12 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00 COMPLETED	
		155272	B. WIN			04/13/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
KINDDEI	O TO A NOITIONIAL C	CARE AND DELIAR CASTLETON		1	82ND ST IAPOLIS, IN46250	
	KINDRED TRANSITIONAL CARE AND REHAB-CASTLETC			INDIAN	IAPOLIS, IN46250	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)	+	IAG	accomplished for those	DAIL
	A Physician's Order, dated 03/21/11,				residents with the potentia	
					to be affected.	1
	· ·	s not limited to, orders			to be affected.	
		venous doppler study to			Resident interviews were	
	_	eg and Lasix 40 mg by				
	mouth as a one ti	me now order.			conducted on April 10, 2011	l I
					ensure that no other allegation	ons
	A preliminary report for "Lower				of abuse were present.	
	Extremity Venous Duplex," dated				Department Heads were	
	03/21/11, indicated negative for DVT				educated by ED/DDCO on	
	(deep vein thrombosis) of the right leg.				4-7-11, Staff Development	1
					Coordinator on 4-20-11, and	
		rt which examined the			4-21-11 with respect to police	cy
		ght tibia and fibula, dated			and procedure	
	03/21/11, indicat				reporting/investigation of	
	indication of frac	eture			allegations.	
					Staff was educated on 4-7-1	1,
		rt which examined the			4-12-11, 4-21-11 and 4-	
	right pelvis, hip a				21-11 with regards to the	
	03/24/11, indicat	ed"No recent	immediate reporting of any			
	fracture"				such allegations of abuse to	the
					ED/DNS/designee.	
		on 03/25/11, at 1100			ED is taking disciplinary	
	` '	cated, "Bruising cont			action with Staff regarding	
	{continued} to R	(right) leg"			failure to follow the Abuse	
					Policy and protocol and the	
	· ·	on 03/28/11, at 0830 (8:30			need to report incidents	
	/ /	."Rt {right} leg {with}			immediately.	
	_	nt offered pain med			ED met with Resident Coun	
	{medication}."				on April 29, 2011 to review	l I
					Abuse Policy and protocol a	and
		on 03/31/11, at 11:00			the need to report incidents	
		esident C was assessed			immediately.	
	by the NP. The b	oruising is noted in the			If a resident has a fall and a	

000172

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155272	B. WIN			04/13/2011	
		<u> </u>	P. (111)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R			82ND ST		
	KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON		_		APOLIS, IN46250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	<b>+</b>	R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	· · · · · · · · · · · · · · · · · · ·	DATE	
	nurses note as"purple in color to inner				subsequent negative x-ray for	or a	
		} thigh - yellowish			fracture, and resident		
	bruising to outer	leg"			continues to complain of pa		
					or demonstrates any change		
	1 -	rder, dated 04/1/11,			condition, the resident will be		
	indicated to send Resident C to the				sent to the hospital for furth	er	
	hospital for X-ray of the right hip, pelvis,				evaluation.		
	femur and patell	a"severe pain/					
	bruising."				What measures will be put	t in	
					place/systemic changes ma	ıde	
	A radiology report, dated 04/01/11, at				to ensure correction &		
	12:33 p.m., which examined the right				How the facility plans to		
	knee indicated,"Impression: 1.				monitor its performance to	)	
	Nondisplaced transverse fracture of the				make sure those solutions		
	proximal tibial r				maintained.		
					All doors will be locked 24/	7.	
	A Physician's O	rder, dated 04/01/11,			The main entrance will be		
	1 -	d Resident C to the			staffing during normal		
		n to have treatment by an			business hours.		
		or for the right proximal			Cameras will be installed at		
		"He is aware pt. [patient]			the front door entrance, the		
	is coming."	. The is aware pt. [patient]			Cambridge Unit entrance an	d	
	is coming.				the staff entrance. The staff		
	Δ Nurses Note	on 04/01/11, at an			the unit will have the		
	1	dicated, " Resident			responsibility to allow or de	nv	
	1	ER with a Plaster (sic)			entry to the facility who not	· I	
		` '			not use the main entrance.	uo	
		c) to R {right} Leg					
	(sic)"				Staff on the units will be		
		04/07/11 + 2.20			responsible to ensure that		
		on 04/07/11, at 2:20 p.m.,			visitors sign in.		
		I the resident was at risk			If a visitor refuses to sign in	or	
	_	due to her age and weight			becomes threatening in any		
	1	bearing status. She			way, the visitor will be aske		
	indicated the res	ident was not receiving			to leave the premises. If they	y	

KINDRED TR  (X4) ID PREFIX TAG  cal una ind tran  Du 04/ he bec tota ass ask on tim tibi	VIDER OR SUPPLIER  RANSITIONAL C  SUMMARY ST  (EACH DEFICIENC  REGULATORY OR	ARE AND REHAB-CASTLETON  TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	5226 INDIA	T ADDRESS, CITY, STATE, ZIP CODE E 82ND ST ANAPOLIS, IN46250	COMPLETED 04/13/2011	
KINDRED TR  (X4) ID PREFIX TAG  cal una ind tran  Du 04/ he bec tota ass ask on tim tibi	SUMMARY ST (EACH DEFICIENC REGULATORY OR P alcium supplemental control of the car	TARE AND REHAB-CASTLETON TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	B. WING  STREE  5226  INDIA	E 82ND ST	04/13/2011	
KINDRED TR  (X4) ID PREFIX TAG  cal una ind tran  Du 04/ he bec tota ass ask on tim tibi	SUMMARY ST (EACH DEFICIENC REGULATORY OR P alcium supplemental control of the car	ARE AND REHAB-CASTLETON  TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	STREE 5226 INDI/	E 82ND ST	1	
KINDRED TR  (X4) ID PREFIX TAG  cal una ind tran  Du 04/ he bec tota ass ask on tim tibi	SUMMARY ST (EACH DEFICIENC REGULATORY OR P alcium supplemental control of the car	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	INDIA			
(X4) ID PREFIX TAG  cal una ind trai  Du 04/ he bec tota ass ask on tim tibi	SUMMARY ST (EACH DEFICIENCE REGULATORY OR I alcium supplementation of the ca	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID	ANAPOLIS, IN46250		
PREFIX TAG  cal una ind train train tibit train	(EACH DEFICIENCE REGULATORY OR PARTIES OF THE CALCIUM SUPPLEMENT (EACH DEFICIENCE OF THE CALCIUM	CY MUST BE PERCEDED BY FULL				
Du 04/he bed tota ass ask on tim tibi	REGULATORY OR Ralcium supplemental supplemen		DDEEDA	PROVIDER'S PLAN OF CORRECTION	(X5)	
cal una ind tran  Du 04/ he bec tota ass ask on tim tibi	alcium supplements	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
Du 04/he bed tota ass ask on tim tibi	naware of the ca	calcium supplements. NP indicated she is		<u> </u>	DATE	
Du 04/he bed tota ass ask on tim tibi				refuse, police will be notifi Maintenance personnel wil		
Du 04/he bed tota ass ask on time tibe	idicated Resider			-	I	
Du 04/he bed tota ass ask on time tibi	C 1			check locks according to the		
he bed total ass ask on time tibi	ansfer to a whee	ei chair.		preventative schedule daily		
he bed total ass ask on time tibi		6.1		and prn. The Supervisor w		
he bed total ass ask on time tibi	During the end of day conference on			be responsible for checking	g the	
bed tota ass ask on tim tibi	04/07/11, at 5:00 p.m., the DNS indicated			doors on the weekends.		
tota ass ask on tim tibi	he did not report the fracture to the state			The facility has posted noti		
ass ask on tim tibi	because Resident C was not considered			at each entrance outlining t	he	
ask on tim tibi	totally dependent according to the MDS			new security system.		
on tim tibi	assessment of the resident. The DNS was			Daily resident rounds will		
tim tibi	asked to provide any further information			performed by the ED/DNS	I	
tibi	on investigation or reporting from the			unit managers to identify a		
In	time it was discovered Resident C had a			address concerns promptly		
I .	bia fracture.			Department Managers will	l be	
I .				educated to Kindred's Ang	el	
9.1	n the morning co	onference on 04/08/11, at		Care program by May 5, 20	011	
1 7.1	:15 a.m., the DN	IS did not provide any		and they will be required to	)	
fur	ırther document	ation of an investigation		visit their assigned resident	ts	
rela	elated to the tibia	a fracture of Resident C.		2-3 times weekly, with a		
Не	le indicated he b	elieved the injury was		weekly call made to the		
rela	elated to the resi	dent's diagnosis of		residents' responsible party		
ost	steoporosis and	osteoarthritis. He		and a weekly summary turn	ned	
ind	ndicated he did r	not report the incident to		into the ED. Any concerns		
the	ne state based or	the MDS assessment of		will be brought to the daily	,	
Re	esident C. The	Administrator did not		clinical meeting with a		
pro	rovide any furth	er documentation		resolution indicated within	24	
cor	oncerning the til	oia fracture of Resident		hours. ED/DNS will monit	tor	
C.	·			weekly summaries to ensur	re	
				resolution.		
On	on 04/08/11, at 1	0:30 a.m., the DNS		Resident interviews will be		
pro	rovided A Resid	ent Event Report		conducted by SS, on a		
1 -		report indicated the event		quarterly basis, using the		
dat			1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
On	on 04/08/11, at 1	•		resolution. Resident interviews will be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155272	B. WING		04/13/2011
NAME OF F	ROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
			I	82ND ST	
KINDREI	) TRANSITIONAL C	CARE AND REHAB-CASTLETON	INDIAN	IAPOLIS, IN46250	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	The event was lis			system questions to ensure	
		ircumstances Unknown"		integrity of the process. Any	
		Also listed in the report is		concerns will be brought to	
	· ·	porosis. The worksheet		ED immediately for follow	-
	indicated the phy	•		Results of the interviews wi	
		d DNS were notified on		be reviewed by the ED/DNS	
		p.m. The box "Reported		New orders will be reviewed	ed
	to State" was mar	rked "no."		in daily clinical meeting to	
				ensure that x-rays receive	
	In an interview o	n 04/08/11, at 11:30 a.m.,		timely follow up, pain	
	the Brookshire U	nit Manager indicated		medication changes are	
	Resident C had a	n initial investigation of		addressed, care plans are	
	the original bruis	e done on 03/18/11. "I		updated appropriately and	
	did not know I ha	ad to do another one for		condition changes are	
	the fracture."			responded to expediently.	
				An abuse in-service will be	
	This Federal tag	relates to complaint		done on a quarterly basis.	
	IN00088559.			Clinical Case Managers and	l/or
				MDS coordinators will be	
	3.1-28(c)			responsible to ensure that ca	are
				plans are updated timely and	d
				are comprehensive.	
				DNS/designee will monitor	
				care plans for compliance of	n a
				quarterly basis.	
				ED will meet with the reside	ent
				council weekly x 1 month a	nd
				then monthly thereafter.	
				Resident council president h	nas
				been informed that he may	
				request a meeting at any tim	ne
				and will be given contact	
				information.	
				Investigations will be	
				mvestigations will be	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	00 	COMPLETED
		155272	B. WING		04/13/2011
NAME OF I	PROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE	
KINIDREI	TRANSITIONAL C	CARE AND REHAB-CASTLETON		82ND ST IAPOLIS, IN46250	
				1A1 OLIS, 11140230	1
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
		,		conducted using a systemati	
				approach under the guidance	
				of Kindred policy to ensure	
				that the investigation is	
				comprehensive in nature.	
				· Any staff member	
				accused of abuse will be	
				suspended immediately	
				pending the investigation.	
				Kindred has a zero tolerance	e
				policy for abuse of any kind	
				and will take whatever steps	3
				necessary to ensure the	
				protection of our residents.	
				· Allegations of abuse a	and
				all incidents of unusual	
				occurrences (as defined by	
				Indiana Code) will be report	
				to officials in accordance the	e
				regulations and Kindred	
				policy.	
				5. Executive Director is	,,
				responsible to ensure over	l l
				compliance by May 9, 201	1.
F0226	written policies an	levelop and implement d procedures that prohibit lect, and abuse of residents			
		ion of resident property.			
SS=J		ord review and interview,	F0226	This serves as the Allegation of	of 05/09/2011
	-	to thoroughly investigate		Compliance for Kindred Transitional Care & Rehabilita	tion
	_	sexual abuse by 1 resident		Center-Castleton for the recer	
	and ensure reside	ents were protected from		complaint survey dated 04/13/ Kindred Transitional Care &	l l

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155272	B. WIN			04/13/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIEI	8			82ND ST	
KINDRE	D TRANSITIONAL (	CARE AND REHAB-CASTLETON			APOLIS, IN46250	
(X4) ID		STATEMENT OF DEFICIENCIES	_	ID	,	(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	-	ndicated by facility policy	1		Rehabilitation Center-Castleto	-
		tions of abuse reviewed.			asserts that all corrections	
	1	ractice resulted in			described on this Plan of	
	_				Correction have been	
	immediate jeopa	ray. Resident B.			implemented. In regards to the	e
	The Immediate Jeopardy was identified on 4/06/11 and began on 3/24/11. The				specific deficiencies, we have outlined our corrective actions	
					and continued interventions to	
					assure compliance with	
	Administrator, I	Director of Social			regulations and our plan of act	tion.
	Services, and the District Director of Clinical Operations were notified of the immediate jeopardy on 4/06/11. The				The staff of Kindred Transition	
					Care & Rehabilitation	
					Center-Castleton is committed	
	Immediate Jeopardy was removed on 4/10/11, but the facility remained out of				delivering high quality health of to its residents to obtain their	are
					highest level of physical, ment	al.
		e level of isolated, no			and psychosocial functioning.	
	_	potential for more than			respectfully submit Kindred	
		•			Transitional Care & Rehabilita	
		at is not immediate			Center-Castleton is in substan	
	1	e the facility was			compliance as set forth below, are confident that it will be four	•
	"	vicing, educating, and			in substantial compliance with	
	_	nployees for knowledge			regulations upon re-survey. T	•
	and compliance	with building and			statements made on the plan	
	visitation policie	es and policies and			correction are not an admissio	n
	procedures relate	ed to investigating and			to and do not constitute an	
	reporting injurie	s of unknown injury and			agreement with the alleged	
	allegations of ab				deficiencies herein.	
					F226	
	B Based on reco	ord review and interview,				
		d to re-investigate and				.
		e agencies a fracture of			How corrective actions wil	1
	_	_			be accomplished for the	
	1	as indicated by facility			residents affected.	
	1 -	residents reviewed for				
	I -	own origin in a sample of			Resident B allegation has be	en
	5.				fully investigated and currer	ıtly
					resides in the facility. SS	
	A.1. A facility p	oolicy titled "Abuse,"				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155272	B. WIN			04/13/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
KINDDE	O TO A NOITIONIAL C	CARE AND DELIAR CASTLETON		1	82ND ST	
		CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG			+	IAG	continues to meet with the	DATE
	dated 10/31/09, received from the Administrator on 4/06/11 at 4:45 p.m.				resident to address any long	
	indicated:	14/00/11 at 4.43 p.m.			term effect.	
	marcated.				Resident C fracture has beer	.
	"Daliary Vambal	coursel mhyroidael and				1
	"Policy: Verbal, sexual, physical, and mental abuseare strictly prohibited.				fully investigated and continues to reside in the	
	mentai abuseai	e strictly prombited.				
	Commission	Jolings 14 Degults of an			facility.	
	1 0	lelines: 14. Results of an				
	alleged abuse investigation are reported to the Executive Director (Administrator) or their designee and to other officials in					
					H	1
					How corrective action will	pe
	accordance with state law"				accomplished for those	,
	A facilita a aliana	4:41 - 4 11 C - 11 d - 12 d -			residents with the potentia	1
		titled "Conducting an			to be affected.	
	•	ated 7/22/10 and received			IC	
		strator on 4/06/11 at 4:45			If a resident has a fall and a	
	p.m., indicated:				subsequent negative x-ray for	or a
		ral regulation requires a			fracture, and resident	
		ence that all allegations of	continues to complain of pain			
		ughly investigated. In			or demonstrates any change condition, the resident will be	
		ter must tale action to			1	
	-	otential abuse while the			sent to the hospital for furth	žI
	investigation is in	n progress.			evaluation. Resident interviews were	
	Dwaaadaaa					to
	Procedure				conducted on April 10, 2011	
	O Intomio	Emambara viisitara			ensure that no other allegation	JIIS
		f members, visitors,			of abuse were present.	
	and/or residents	•			The ED/designee, will revie	
	_	eged incident being			investigations conducted ov	
	mivestigated. Inte	erviews may include:			the last two months to assure	=
	- C1 - CC :1 ·	1 C (l ( ) ( 1			full implementation of	
		d for the resident(s) at the			facilities policies was	
	time of the allege	ed incident.			achieved. Counseling and	
					in-servicing will be conduct	ea

l l		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155272	B. WIN	G		04/13/2011
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	
				1	82ND ST	
KINDREI	D TRANSITIONAL C	CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	b. Staff on other shifts				on any noted discrepancies.	
					The ED, or designee will	
	c. Residents in the same room, or				monitor through record revi	ew
	residents in the in	mmediate vicinity			at least monthly for three	
					months, then quarterly, to	
	d. Visitors who may have witnessed the				assure all components of the	
	incident				Abuse/Unusual Occurances	
					Policies are fully implement	ed.
	12. Identify the cognitive status of the victim(s) and resident(s) who are				The ED is responsible for	
					overall compliance.	
	witnesses  16. Describe any action(s) taken by the					
					What measures will be put	t in
					place/systemic changes ma	de
	center to protect	the resident(s) and to			to ensure correction.	
	prevent a possibl	e reoccurrence				
					· Any staff member	
	20. If the allegati	on involves sexual			accused of abuse will be	
	abuse, document	if the alleged victim was			suspended immediately	
	examined, and if	so, obtain a copyof the			pending the investigation.	
	examination or st	tatement from the			Kindred has a zero tolerance	
	examiner				policy for abuse of any kind	
					and will take whatever steps	;
	27. Upon conclus	sion of the investigation,			necessary to ensure the	
	prepare a summa	ry report of the findings			protection of our residents.	
	and conclusions.	The summary report			· Allegations of abuse a	and
	must include suff	ficient detail of the			unusual occurrences will be	
	investigation; any	y actions taken by the			reported to officials in	
	centerand a sur	nmary of the findings.			accordance with regulatory	
					requirements and Kindred	
	A 2. The record of	of Resident B was			policy.	
	reviewed on 4/06	6/11 at 11:00 a.m.			Policy and Procedure	
					regarding the investigating a	and
	Diagnoses includ	led, but were not limited			reporting of incidents and	
	1 -	rsonality disorder,			allegations have been review	ved

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155272	B. WIN			04/13/2	011
		1	D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		1	82ND ST		
KINDRE	D TRANSITIONAL (	CARE AND REHAB-CASTLETON			IAPOLIS, IN46250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	+	TAG	<u> </u>		DATE
	1	nistory of uterine and			with the ED/DNS and SW b	у	
	breast cancer, beriberi, severe				the DO and DDCO.		
	malnutrition, and	d hepatitis B.			· The staff has been		
					inserviced on the abuse poli	cy	
	Resident B's admission Minimum Data				and unusual occurrence		
	Set (M.D.S.) assessment, dated 2/24/2011,				policy. Future inservices w	ill	
	indicated she did not experience				be conducted on a quarterly		
	hallucinations or delusions.				basis.		
	Resident B's record did not contain any						
	documentation of Resident B having a				How the facility plans to		
	guardian or an appointed power of				monitor its performance to	0	
	attorney.				make sure those solutions		
					maintained.		
	A Recapitulation	of Physician's Orders for			I mumeumeur		
	1 *	a physician's order, dated			All allegations of abuse and		
		h indicated "Resident is			unusual occurrences will be		
		ng his/her own health					
	decisions."	ng ms/ner own nearm		discussed at the PI meetings			
	decisions.				monthly.		
	A "Facility Incid	lent Reporting Form"			Executive Director is		
	provided by the	Director of Nursing			responsible to ensure over	all	
	1 ^	.) on 4/06/11 at 10:00			compliance by May 9, 201		
	,	eted by him indicated:					
		,					
	"Incident Date: 3	3/24/2011					
	Resident Name:	(Resident B)					
	_	n of Incident: Resident					
	1 ^	Jnit manager and the					
	sosial (sic) servi	ce Director, that					
	allegation of rap	e. (sic) when asked when					
	it happened, resi	dent stated it happened					

000172

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	A. BUII	LDING	NSTRUCTION  00	(X3) DATE COMPI 04/13/2	LETED
		199272	B. WIN		DDDEGG GUTY GTATE ZID GODE	04/13/2	.011
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON					APOLIS, IN46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
		nt unable to describe	1				5.112
	_	when asked. asked if					
	* *	ho did it, he (sic) said his					
	name was "rock"	and he does not work					
	here. asked if she	e could describe him, all					
	she said was, he	is dark skin and has good					
	_	ent she (sic) gas already					
		and her daughter and					
	_ ·	picking her up after					
		ontinue to repeat the same					
	statement over and over. she was unable to give any further information and						
		asked. when questioned					
	_	sic) she said yes, staff					
		nan has already left."					
		man nas anoaay 1010.					
	The "Facility Inc	ident Reporting Form"					
	_	I not document the date					
	or time the repor	t was completed, or the					
	time Resident B	made the allegation of					
	rape.						
		ess Note, dated 3/25/11 at					
	·	ated "Reported to this					
	` /	ocial Service Director le an allegation of					
		sident-stated 'I was					
		she knew when it					
	-	'Yes it happened last					
	night'"						
	A facility "Resid	ent Event Report					
		ived from the D.N.S. on					
	4/07/11 at 5:00 p	.m., indicated the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00			ETED
		155272	B. WIN			04/13/2	011
NAME OF I	PROVIDER OR SUPPLIER	•	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					82ND ST		
KINDRE	KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON			INDIAN	IAPOLIS, IN46250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTIO			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		d been advised of					
		gation of rape on 3/25/11					
		iring an interview on					
		.m., the Administrator					
		d not participated in any					
	I -	rigation of Resident B's					
	allegation of rape	<del>2</del> .					
	Resident B was i	nterviewed on 4/07/11 at					
	4:00 p.m., in private in her room. She was pleasant and cooperative. When asked						
	about her allegation of rape, she refused to						
	1	ded the interview.					
	discuss it and circ	ded the interview.					
	During an intervi	iew with the Social					
	_	on 4/07/11 at 5:00 p.m.,					
		and Administrator present					
		oies of two resident					
		13/25/11, she indicated					
		g Resident B's allegation					
	_	S. and Administrator					
	had no explanation						
		as not included in					
	documentation p	rovided earlier.					
	A Social Services	s Progress Note, dated					
	3/25/11 at 1:30 p	.m., indicated "This					
	writer (symbol for	or "and") UM (unit					
	manager) went t	o speak to (name of					
	resident) to follo	w up with investigation.					
	This writer asked	d (name of resident) if she					
	heard anything la	ast night R/T (related to)					
	1	l. (Name of resident)					
	stated No (symb	ool for "and") that she					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155272	A. BUI	LDING	00	04/13/2	
		150272	B. WIN		A PARAGO CITY CTATE TIN CORE	04/13/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE 82ND ST		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-CASTLETON	1	1	APOLIS, IN46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD		T-F	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	slept all night hea	ard nothing."					
	A Social Services	s Progress Note, dated					
	3/25/11 at 1:35 p	.m., indicated "This					
	writer went to sp	eak with (name of					
	resident) in regar	ds to investigation.					
	(Name of residen	nt) stated he did not hear					
	anything last noc	(night) it was pretty					
	quiet"						
	During interviews on 4/06/2011 at 10:30						
	a.m., and again a	t 4:30 p.m., the D.N.S.					
	indicated he had	not interviewed any					
	residents, staff, o	r visitors following					
	Resident B's alle	gation of rape, and had					
	not done any oth	er investigation or					
	instituted any int	erventions to assure					
	resident safety.						
	D 1 The Clinica	al Record of Resident C					
		04/08/11 at 11:50 a.m.					
	was reviewed on	04/06/11 at 11.30 a.iii.					
	Diagnoses includ	led, but are not limited to,					
	dementia, malais						
	· ·	eumatoid arthritis,					
	osteoarthritis, and						
	The Minimum D	ata Sheet (MDS)					
	assessment, dated	d 02/21/11, triggered					
	Resident C as mo	oderately impaired in					
	cognition. The N	MDS assessment					
	indicated Resider	nt C required extensive					
	assistance with o	ne staff person when					
	transferred.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	NSTRUCTION  00		3) DATE SURVEY COMPLETED 04/13/2011	
	PROVIDER OR SUPPLIER		B. WIN	5226 E	 DDRESS, CITY, STATE, ZIP COE 82ND ST APOLIS, IN46250		5-7/10/2011
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
TAG	A current Recapithru 04/30/11, without of 11/19/10, indiagnosis}ost  A Care Plan titled most recent update "Res. {resident} (sic) decision-macues/reorientation memory; cannot five minutes, such penny"  A Care Plan titled with the most recent indicated"Residents with the most	tulation, dated 04/1/11 ith an original order date cated Resident C "DX" eoporosis"  d, "Cognition," with the te of 02/21/11, indicated, has impaired cognition & tking abilities (needs n); poor s/t [short term] recall three items after h as "clock, table,  d, "Communication," tent update of 02/21/11, dent has potential for		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
	dated 03/18/11, a	t Report Worksheet, at 10:30 a.m., indicated in interviewed relative to					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING		NSTRUCTION  00	(X3) DATE: COMPL 04/13/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	unaware of the or Resident C indict when transferred sure" The box cause" was mark "Circumstances. The report indicated Nursing Services Administrator not applicable as indicated box "N/A."  A Nurses Note, of (6:30 p.m.), indicting edema to leg was warm to moved. Resident physician's answ and a doppler stuncted also indicated supervisor was in A Nurses Note, of (8:00 a.m.), indicting pain [with] att. The nurse indicated Practitioner (NP) of attorney.  A Physician's Or included, but was for an X-ray and	Unknown" was marked.  Inted the Director of Is (DNS) and the Interest of the orifications were not icated by a mark in the  Idated 03/20/11, at 1830 Interest of the original toward leg. The touch and tender when the original toward leg. The touch and tender when the original toward leg. The touch and tender when the original toward leg. The touch and tender when the original toward leg. The touch and tender when the original tender was called the weekend.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155272	A. BUI	LDING	00	COMPL 04/13/2	
		199272	B. WIN			04/13/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-CASTLETO	N		82ND ST APOLIS, IN46250		
			`		1 0210, 114-0200		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
-	mouth as a one ti			_			
		inio no w order.					
	A preliminary rej	port for "Lower					
	Extremity Venou	•					
	1	ed negative for DVT					
	· ·	abosis) of the right leg.					
	(ucop vom umom	100010) 01 4114 118114 148.					
	A radiology repo	rt which examined the					
		ght tibia and fibula, dated					
	03/21/11, indicat						
	indication of frac						
	A radiology repo	rt which examined the					
	right pelvis, hip a						
	03/24/11, indicat						
	fracture"						
	A Nurses Note, o	on 03/25/11, at 1100					
	[	cated, "Bruising cont					
	[continued] to R						
	A Nurses Note, o	on 03/28/11, at 0830 (8:30					
	· ·	."Rt [right] leg [with]					
	/ ·	nt offered pain med					
	{medication}."	•					
	A Nurses Note, o	on 03/31/11, at 11:00					
	a.m., indicated R	esident C was assessed					
	by the NP. The b	bruising is noted in the					
	nurses note as	"purple in color to inner					
		thigh - yellowish					
	bruising to outer						
	A Physician's Or	der, dated 04/1/11,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155272		(X2) M A. BUII		ONSTRUCTION 00	(X3) DATE COMPI 04/13/2	LETED	
		155272	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/13/2	.011
NAME OF F	PROVIDER OR SUPPLIER				82ND ST		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-CASTLETON		1	APOLIS, IN46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
	indicated to send	Resident C to the					
		y of the right hip, pelvis,					
	femur and patella	a"severe pain/					
	bruising."						
	A radiology repo	rt, dated 04/01/11, at					
		h examined the right					
	knee indicated,	•					
		nsverse fracture of the					
	proximal tibial m	ietapnysis					
	A Physician's Or	der, dated 04/01/11,					
	indicated to send	Resident C to the					
		to have treatment by an					
	•	r for the right proximal					
	is coming."	'He is aware pt. {patient}					
	A Nurses Note, o	on 04/01/11, at an					
	illegible time, inc	dicated, " Resident					
		ER with a Plaster (sic)					
	• `	c) to R [right] Leg					
	(sic)"						
	In an interview o	n 04/07/11, at 2:20 p.m.,					
		the resident was at risk					
	•	due to her age and weight					
	_	bearing status. She					
		dent was not receiving ents. NP indicated she is					
		ause of the fracture. NP					
		nt C needs assist to					
	transfer to a whee	el chair.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155272	B. WING			04/13/20	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER				82ND ST		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-CASTLETON		INDIAN	APOLIS, IN46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	гЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	-	DATE
	_	f day conference on					
	· ·	p.m., the DNS indicated					
	_	the fracture to the state					
		t C was not considered					
		t according to the MDS					
		e resident. The DNS was					
	1	any further information					
	_	or reporting from the					
		vered Resident C had a					
	tibia fracture.						
		onference on 04/08/11, at					
		NS did not provide any					
	further document	tation of an investigation					
	related to the tibi	a fracture of Resident C.					
	He indicated he b	pelieved the injury was					
	related to the resi	ident's diagnosis of					
	osteoporosis and	osteoarthritis. He					
	indicated he did	not report the incident to					
	the state based or	n the MDS assessment of					
	Resident C. The	Administrator did not					
	provide any furth	ner documentation					
	concerning the ti	bia fracture of Resident					
	C.						
	On 04/08/11, at 1	10:30 a.m., the DNS					
	provided A Resid	lent Event Report					
	Worksheet. The	report indicated the event					
	date and time wa	s 04/01/11 at 6:00 p.m.					
	The event was list	sted as a right leg					
	fracture. The "C	ircumstances Unknown"					
	box is marked. A	Also listed in the report is					
		pporosis. The worksheet					
	indicated the phy	•	<u> </u>				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/06/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		OO	(X3) DATE S COMPL	ETED		
		155272	B. WING			04/13/2	U11	
	ROVIDER OR SUPPLIER O TRANSITIONAL C	CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE  5226 E 82ND ST INDIANAPOLIS, IN46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	04/01/11 at 6:00 to State" was man	d DNS were notified on p.m. The box "Reported rked "no." relates to complaint						
F0279	The facility must do care plan for each measurable object meet a resident's imental and psycholidentified in the coordinate to be furnished resident's highest mental, and psycholidentified under §44 would otherwise but are not provide exercise of rights in the right to refuse	the results of the velop, review and revise the hensive plan of care.  evelop a comprehensive resident that includes tives and timetables to medical, nursing, and psocial needs that are mprehensive assessment.  It describe the services that do to attain or maintain the practicable physical, posocial well-being as 83.25; and any services that the required under §483.25 and due to the resident's under §483.10, including treatment under §483.10(b)						
SS=D	(4). Based on observa	ation, record review and	F0279		This serves as the Allegation of	of	05/09/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

A97U11

Facility ID:

000172

If continuation sheet

Page 30 of 37

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155272	B. WIN			04/13/20	011
		<u> </u>	D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			82ND ST		
KINDRE	D TRANSITIONAL (	CARE AND REHAB-CASTLETON		1	IAPOLIS, IN46250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAU		· · · · · · · · · · · · · · · · · · ·		IAU	Compliance for Kindred		DATE
	· ·	cility failed to ensure			Transitional Care & Rehabilita	tion	
	I -	and comfort needs were			Center-Castleton for the recen		
	1 *	loping and implementing			complaint survey dated 04/13/		
	comprehensive of	care plans for 2 residents			Kindred Transitional Care &		
	(Residents C and	d D) upon their return to			Rehabilitation Center-Castleto	n	
	the facility follo	wing orthopedic treatment			asserts that all corrections		
	for fractures of 4	4 residents reviewed for			described on this Plan of Correction have been		
	care plans in a sa	ample of 5.			implemented. In regards to th	e	
	1	•			specific deficiencies, we have		
	Findings include	·			outlined our corrective actions		
	i mamgs meraac				and continued interventions to	,	
	A facility policy	titled "Core Plane" dated			assure compliance with		
		titled "Care Plans," dated			regulations and our plan of act The staff of Kindred Transition		
	10/31/09, was re				Care & Rehabilitation	aı	
	1	n 4/08/11 at 1:50 p.m. and			Center-Castleton is committee	l to	
		he facility's current policy			delivering high quality health of		
	indicated:				to its residents to obtain their		
					highest level of physical, ment		
	"Policy: A comp	rehensive care plan is			and psychosocial functioning.	We	
	developed that is	s consistent with the			respectfully submit Kindred Transitional Care & Rehabilita	tion	
	resident's specifi	ic conditions, risks, needs,			Center-Castleton is in substan		
	1 -	rences and with standards			compliance as set forth below.		
		ding measurable			are confident that it will be fou		
	_	ventions/services, and			in substantial compliance with		
	1 "	eet the resident's needs s			regulations upon re-survey. T		
	1	resident's assessmentor			statements made on the plan correction are not an admission		
	1				to and do not constitute an	"	
	changes in the re	esident's condition			agreement with the alleged		
	4 751	1 4 11			deficiencies herein.		
	_	b. Addresses risk					
	1	nt lead to avoidable					
	1	tioning or functional			F279		
	levels"						
					How corrective action will	he	
	1. The record of	Resident D was reviewed			accomplished for resident	~~	
	on 4/09/11 at 11	:00 a.m.			accompnished for resident		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	155272	A. BUII		<del></del>	04/13/2011
		133272	B. WIN			04/13/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
KINDREI	TRANSITIONAL C	CARE AND REHAB-CASTLETON		l	82ND ST IAPOLIS, IN46250	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	regozin our ou	250 152.(111 111(0 111 0 1111 1110))			affected.	5.112
	Diagnoses includ	led, but were not limited			arrected.	
	_	iration pneumonia,			Resident record was review	ed
		to thrive, hypertension,			for physician and hospital	cu
	history of multip				discharge orders for	
	fibrillation, and o				transcription accuracy and	
	inormation, and c	osteoporosis.			implementation. The care p	Jan
	Nursa's notes for	Resident D indicated:			was updated for Resident C	
	indisc s notes for	Resident D maleated.			4-7-11 and Resident D on	OII
	"2/27/ 2:15 a m	Resident found on floor			4-12-11 by the unit manage	r
		c/o (complained of) pain			and follow up on by the DN	
		ight") wristsmall			and follow up on by the Div	
	amount of edema				How corrective action will	ho
	amount of edema	1			accomplished for those	i De
	2/27/11 4:20 n m	right wrist is swollen			residents having the	
	-	were found in the x-ray			potential to be affected.	
	out no mactures v	were found in the x-ray			potential to be affected.	
	   3/01/11   right wi	rist still very swollen			Admission, readmissions an	nd
		inst still very swellen			current charts are reviewed	
	3/5/11 2:15 n m	wrist remains swollen,			clinical meeting to ensure th	
	pt. (patient) favor				orders were transcribed and	
	pr. (parient) iavo	is right wrist			implemented correctly and	
	   3/16/11 11:30 n r	nEvening nurse called			care planned as appropriate.	
	-	rayorders to send out to			The promite as appropriate.	
	(name of hospita				What measures will be pu	t in
	stabilization/imm				place/systemic changes ma	
					to ensure correction.	
	   3/17/11 5:30 a m	. Pt. returned from (name			o distriction.	
		an ace wrapped splint in			New admission, readmission	n
	place"	acc mapped spinit in			orders and new orders will b	
	P.4400				reviewed daily at the morning	
	A radiology repo	ort, dated 3/16/11,			clinical meeting for	~~   °
		ssion: Colles fracture			transcription accuracy	
	•	Right wrist: Fracture			a amborrphon accuracy	
	115111. Commicht.	Tagni wiisi. I iaciuic				

000172

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155272	B. WIN	G		04/13/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
KINDDE	D TO ANOITION AL C	ARE AND RELIAD CASTLETON		1	82ND ST	
KINDREL	D TRANSITIONAL C	CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	` ′	f the redius wih mild			implementation and care pla	ins
	· •	ent of the distal fractured			as appropriate.	
	fragment."				Any errors will be followed	-
					on, corrected and/or clarified	d
		ord indicated he was			and education provided as	
		l speciality Orthopedic			necessary.	_
		tion and treatment on			On weekends and holidays,	the
	3/17/11. He retu				nursing supervisor is	
		n documentation tiled			responsible to review new	
		ctions" which included,			orders to ensure prompt and	l l
	but were not limi	ited to:			accurate implementation and	d
					care planning.	
	` • ′	: Wrist fracture, closed.				
	Misc Instr (Misc	ellaneous instructions) 1:			How the facility plans to	
	Ortho-RICE (Res	st, Ice, Compression,			monitor its performance to	
	Elevation)				make sure those solutions	is
	Misc Instr 2: Spl	int Care			sustained.	
		e proper care of your			Irregularities in the	
	splint (or cast)I	Keep it drycontact your			documentation process will	be
	_	nt (or cast) feels too			followed by pertinent	
	tightSEEK IMI	MEDIATE MEDICAL			education and/or counseling	as
	ATTENTION if	you develop severe pain			appropriate by the DNS/SD	C.
	OR you develop				On a quarterly basis, the	
	numbness, tinglii	•			MDS/CM will conduct an	
	discoloration in t	the fingers"			audit to ensure that	
					comprehensive care plans as	re
	Resident D's reco	ord did not contain any			developed and clinical recor	ds
		erventions following his			are accurate.	
	fall and wrist inju	ury and subsequent			DNS/designee will monitor	by
	discovery of his	right wrist facture and			conducting periodic random	
	splinting, includi	ng the aftercare			audits.	
	instructions from	the orthopadic clinic,				
	any orders or dire	ection from his treating			The ED is responsible to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		155272	B. WIN	G		04/13/20	011
NAME OF F	ADOLUDED OD GUDDU IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF F	PROVIDER OR SUPPLIER	-		5226 E	82ND ST		
		CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		rapists who fitted his			ensure overall system		
	splint.				compliance. Completion		
					date		
	During interview	rs on 4/10/11 at 10:45			will be May 9, 2011		
	_	n 4/11/11 at 11:45 a.m.,			•		
	_	ted there was not a care					
	plan for Resident						
	•						
		wing his fracture and					
00.5	subsequent treatr					,	0.7.10.0.12.0.1.1
SS=D	2. The Record of				This serves as the Allegation of Compliance for Kindred	OT	05/09/2011
	reviewed on 04/0	06/11, at 11:50 a.m.			Transitional Care & Rehabilita	tion	
					Center-Castleton for the recen		
	Diagnoses includ	led, but were not limited			complaint survey dated 04/13/		
	to, dementia, ma	laise and fatigue,			Kindred Transitional Care &		
		itis, osteoarthritis,			Rehabilitation Center-Castleto	n	
	hypertension and				asserts that all corrections		
	ny pertension and	differentia.			described on this Plan of		
	The assument Deep	itlation data d			Correction have been implemented. In regards to the	_	
	The current Reca	•			specific deficiencies, we have	·	
		/30/11, with an original			outlined our corrective actions		
	physician's order				and continued interventions to		
	indicated Resider	nt C had a diagnosis of			assure compliance with		
	osteoporosis.				regulations and our plan of act		
					The staff of Kindred Transition	al	
	A care plan titled	l, "Fall Risk Care Plan,"			Care & Rehabilitation Center-Castleton is committed	<sub>Lto</sub>	
	*	ndicated, "Problemrisk			delivering high quality health of		l
	is related to the f	<i>'</i>			to its residents to obtain their		
	issues/diagnoses:				highest level of physical, ment	al,	l
	[osteoporosis]	*			and psychosocial functioning.		
	[ostcoporosis]				respectfully submit Kindred		l
	A E 31				Transitional Care & Rehabilita		
		Jursing Patient Care			Center-Castleton is in substan compliance as set forth below,		
		/01/11, indicated,			are confident that it will be four		
	Resident C was t	reated for a right tibia			in substantial compliance with		
	fracture.				regulations upon re-survey. T	he	l
					statements made on the plan		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155272	A. BUI B. WIN			04/13/2011
NAME OF	PROVIDER OR SUPPLIE	R.			ADDRESS, CITY, STATE, ZIP CODE	
				1	82ND ST	
		CARE AND REHAB-CASTLETON	١		APOLIS, IN46250	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	Emergency Dep	artment Discharge			correction are not an admissio	'n
	1	ed 04/01/11, included, but			to and do not constitute an agreement with the alleged	
		to,"Home Care: You			deficiencies herein.	
	1	splint <u>do not</u> bear weight				
	1	egKeep your leg				
	splintdry"	an ice packKeep the			F279	
	spiiitdry				How corrective action will	ho
	A Resident Ever	nt Report Worksheet, with			accomplished for resident	De
	an event date of	4/01/11 at 6:00 p.m.,			affected.	
	provided by the	Director of Nursing				
	` ′	on 04/08/11 at 10:30			Resident record was reviewed	ed
		he resident had a right leg			for physician and hospital	
	I	port indicated Resident C			discharge orders for	
	had a history of	osteoporosis.			transcription accuracy and	,
	A Nurses Note	dated 04/01/11, at			implementation. The care p	
	· ·	ndicated, "Resident			was updated for Resident C 4-7-11 and Resident D on	on
		with a Plaster (sic) cast or			4-12-11 by the unit manager	r
	Splint (sic) to R	{right} Leg (sic)"			and follow up on by the DN	
		_				
	1	y conference meeting on			How corrective action will	be
		0 p.m., all care plans for			accomplished for those	
		ere requested from the orosis risk factors and for			residents having the	
	1	ctions upon discharge of			potential to be affected.	
	Resident C from	-			Admission, readmissions an	.d
	department on 0				current charts are reviewed	l l
					clinical meeting to ensure th	
		ed "Fractures, " dated			orders were transcribed and	
	04/07/11 was pr	ovided.			implemented correctly and	
	A Como Diam 4141	nd "Dain " detad 04/07/11			care planned as appropriate.	
	was provided.	ed "Pain," dated 04/07/11				
	was provided.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155272	B. WIN			04/13/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	O TO A MOITICNIAL C	NADE AND DELLAR CACTLETON		1	82ND ST		
KINDREI	) TRANSITIONAL (	CARE AND REHAB-CASTLETON		INDIAN	IAPOLIS, IN46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG		DATE	
					What measures will be put		
	_	vation on 04/08/11, at			place/systemic changes ma	ide	
	·	dent C was in a geri-chair			to ensure correction.		
	in the main dinin	g room for a group					
	activity. A large	, bulky ace wrap was			New admission, readmission	1	
	observed around	the resident's right leg.			orders and new orders will b	pe	
					reviewed daily at the morning	ng	
	In the end of day	conference meeting on			clinical meeting for		
	04/08/11, at 5:15	p.m., the DNS indicated			transcription accuracy		
	•	e fall risk care plan stood			implementation and care pla	ins	
		No further care plan			as appropriate.		
		as provided related to			Any errors will be followed	up	
		gnosis of osteoporosis.			on, corrected and/or clarifie	^ I	
	,	plan documentation was			and education provided as		
	_	set dates of the tibia			necessary.		
	fracture and disc				On weekends and holidays,	the	
	emergency depar	•			nursing supervisor is		
	cinergency depar	tilicit.			responsible to review new		
	This Federal tag	relates to complaint			orders to ensure prompt and		
	IN00088559.	relates to complaint			accurate implementation and		
	11100000339.				•	u	
	3.1-35(a)				care planning.		
	3.1-35(a) 3.1-35(b)(1)				II. 41. 6 224		
	\- /\ <del>-</del> /				How the facility plans to		
					monitor its performance to		
					make sure those solutions	is	
					sustained.		
					Irregularities in the		
					documentation process will	be	
					followed by pertinent		
					education and/or counseling	as	
			1		appropriate by the DNS/SD	C.	
			1		On a quarterly basis, the		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENT		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 04/13/2011
	PROVIDER OR SUPPLIER	LARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE  5226 E 82ND ST INDIANAPOLIS, IN46250		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETION DATE	
IAG	REGULATORY OR	LSC IDEN HE YING INFORMATION)	IAG	MDS/CM will conduct an audit to ensure that comprehensive care plans a developed and clinical recording are accurate.  DNS/designee will monitor conducting periodic random audits.  The ED is responsible to ensure overall system compliance. Completion date will be May 9, 2011	re rds by